APPENDIX G
MCO BASELINE ASSESSMENT:
INFORMATION SYSTEM CAPABILITIES

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I. GENERAL INFORMATION

Please provide the following general information.

A. Managed Care Model Type:

HMO-Staff HMO-Group HMO-IPA HMO-Mixed Other: _____

[Managed care model type can affect the quality and completeness of the data and the timeliness of data submission. For example, an HMO-IPA could have a delegated provider payment arrangement with the IPAs it contracts with. Delegation of data collection and provider payment can affect the frequency with which a plan receives data and the quality and completeness of that data. An HMO-Staff model is less likely to have a problem with timeliness since physicians work directly for the plan.]

B. Year Incorporated

_____

C. Member Enrollment for Last Three (3) Years:

	1995	**1994**	**1993**
Privately Insured	_____	_____	_____
Medicare	_____	_____	_____
Medicaid	_____	_____	_____
Other	_____	_____	_____

[Plans where privately insured patients make up more than 90 percent of enrollment may not have adequate systems in place to process experience or enrollment for Medicaid beneficiaries. Verify that the appropriate modifications have been identified and will be made.]

APPENDIX G
MCO BASELINE ASSESSMENT:
INFORMATION SYSTEM CAPABILITIES

II. DATA ACQUISITION CAPABILITIES

The purpose of this section is to obtain a high-level understanding of how you collect and maintain claims/encounters, enrollment information and data on ancillary services such as prescription drugs.

A. Administrative Data (Claims and Encounter Data)

This section requests information on input data sources (e.g., paper and electronic claims) and on the transaction system(s) you use.

1. Do you use standard claims or encounter forms? If so, please specify (e.g., HCFA 1500, UB92).

Hospital: _____
Physician: _____
Drug: _____
Other: _____

[Plans that do not use either HCFA 1500 or UB92 forms may be using forms they developed themselves. If a plan is using its own forms, these forms should be reviewed to ensure they are capturing the following key data elements: patient identification information (SSN, name, date of birth, gender), provider identifying information (Tax ID, name), date of service, place of service and diagnoses and procedure codes.]

2. We would like to understand the means by which claims or encounters are submitted to your plan. We also are interested in an estimate of what percentage (if any) of services provided to your enrollees are not submitted as claims or encounters and therefore are not represented in your administrative data. Please provide the following percentages:

	Claims/Encounter Type				
Medium	**Hospital**	**Physician**		**Drug**	**Other**
		PCP	**Specialist**		
Claims/encounters submitted electronically					
Claims/encounters submitted on paper					
Services not submitted as claims or encounters					
TOTAL	**100%**	**100%**	**100%**	**100%**	**100%**

[Since paper forms need to be entered into a plan's system, processing paper forms is prone to error. If a plan is receiving more than 50 percent of its data on paper forms, verify the data checks the plan uses to test processor accuracy. Electronic data submission should also undergo data edits and validity checks. Plans with a high percentage of unavailable data for a particular category will have difficulty reporting measures that utilize that category. For example, a plan receiving no drug data from its vendor would not be able to report the HEDIS measures for Outpatient Drug Utilization.]

APPENDIX G
MCO BASELINE ASSESSMENT:
INFORMATION SYSTEM CAPABILITIES

3. Please document whether the following data elements are required for each of the types of claims/encounters identified below. If required, enter an "R" in the appropriate box.

	Claims/Encounter Type				
Data Elements	**Hospital**	**Physician**		**Drug**	**Other**
		PCP	**Specialist**		
Patient Gender					
Patient DOB/Age					
Diagnosis					
Procedure					
First Date of Service					
Last Date of Service					
Revenue Code					
Provider Specialty					

[Standard measures of plan performance such as Medicaid HEDIS are dependent upon the availability of the fields listed above. If procedure codes or diagnosis codes are not available, the data will not include the necessary level of detail to report performance measures.]

4. How many diagnoses are captured on each claim? On each encounter?

	Claim	Encounter
Institutional Data:	_____	_____
Professional Data:	_____	_____

[A minimum of two diagnosis codes and two procedure codes should be available. If only one diagnosis is available, it may be difficult to identify patients with chronic conditions such as diabetes and asthma.]

APPENDIX G
MCO BASELINE ASSESSMENT:
INFORMATION SYSTEM CAPABILITIES

5. Can you distinguish between principal and secondary diagnoses?

[Some plans will consider the first diagnosis on the claim to be principal. Other plans determine the principal diagnosis by selecting the most expensive condition represented.]

6. System Overview Flowcharts: Please provide a high-level overview of the structure of your management information system(s).

[While reviewing the overview flowchart, you should be able to clearly follow the path of a claim/encounter as it moves through the plan's system. Look for data translation and conversion points and try to evaluate their effect upon data quality. Look for data entry points- data entry can produce errors. Does the flowchart indicate when claims are rejected ?]

7. Please explain what happens if a claim/encounter is submitted and one or more required fields are missing. incomplete or invalid. For example, if diagnosis is not coded, is the claims examiner required by the system to use an on-line software product like AutoCoder to determine the correct ICD-9 code?

Institutional Data:

Professional Data:

[The use of an automated coding product such as GMIS' AutoCoder can result in more consistent coding of missing information. Plans that do not use such a product may allow processors to make their own decisions on appropriate coding. Processor judgment could result in less accurate coding.]

APPENDIX G
MCO BASELINE ASSESSMENT:
INFORMATION SYSTEM CAPABILITIES

8. What steps do you take to verify the accuracy of submitted information (e.g., procedure code-diagnosis code edits, gender-diagnosis, gender-procedure code edits)?

   Institutional Data:

   Professional Data:

   [For example, plans will often verify that the information in procedure code and diagnosis code fields are valid codes. Plans may also verify that diagnosis and procedure codes are appropriate for age and gender. For example, a claim with a procedure of hysterectomy should be for a female patient.]

9. Under what circumstances can claims processors change claims/encounter information?

   [If processors are given the ability to modify claims/encounter information, the accuracy of that information could be affected either negatively or positively. Processors may simply correct data that was submitted incorrectly which would increase the quality of the data. However, processors may also change diagnosis and procedure codes which could result in a loss of coding specificity. Does the plan check processed data against paper claims?]

10. Identify any instance where the content of a field is intentionally different from the description or intended use of the field. For example, if the dependent's SSN is unknown, do you enter the member's SSN instead?

    [Changing the content of a field can create data processing issues. For example, if the member's SSN is used as an ID number for a dependent, the claim may be given the age and sex of the member rather than the actual patent. The use of the member's SSN would make it difficult to track the dependent's experience over time.]

APPENDIX G
MCO BASELINE ASSESSMENT:
INFORMATION SYSTEM CAPABILITIES

11. Are claims/encounters received directly from the provider (i.e., hospital, physician, pharmacy) or do they go through an intermediary? If the data are submitted through an intermediary, what changes, if any, are made to the data?

[Intermediaries that are processing the data, such as a pharmacy benefit management firm, could modify the data creating a dataset that is inconsistent with the plan's data. The intermediary may define field content differently or may not be using the same fields as the plan making it difficult to integrate the intermediary's data into the plan's systems. All data submitted through an intermediary should be monitored for quality by the plan.]

12. Please estimate the percentage of claims/encounters that are coded using the following coding schemes:

Coding Scheme	Inpatient Diagnosis	Inpatient Procedure	Ambulatory/ Outpatient Diagnosis	Ambulatory/Outpatient Procedure	Drug Diagnosis
ICD-9-CM					
CPT-4					
HCPCS					
DSM-IV					
Internally-Developed					
Other (specify)					
Not Required					
TOTAL	**100%**	**100%**	**100%**	**100%**	**100%**

[If a plan is using internally-developed coding schemes, the State should verify whether this coding can be mapped to standard coding such as ICD-9-CM or CPT-4. If the coding can be translated for reporting purposes (Medicaid HEDIS requires diagnosis and procedure codes), the plan should provide information on the level of specificity with which the coding maps to standard coding (e.g. three-digit specificity or five-digit specificity). If the mapping has a low level of specificity, information on co-morbidities and complications may not be retained during translation.]

APPENDIX G
MCO BASELINE ASSESSMENT:
INFORMATION SYSTEM CAPABILITIES

13. Please describe any recent (i.e., within the last three years) upgrades or consolidations of your information systems.

[Each upgrade or consolidation of the plan's information system has the potential to damage the quality of the data. For example, data could be lost or corrupted during a system conversion, or a new system could limit a plan's access to historical data. Changes in data quality and access will affect the plan's ability to report performance measures and utilization.]

14. For each Medicaid HEDIS measure identified below, please indicate the data source/method you would use:

Medicaid HEDIS Measure	**Administrative Data Only**	**Medical Record Review Only**	**Hybrid Method**
Childhood Immunization Rates			
Well Child Visits			
Adolescent Well Care Visits			
Substance Abuse Counseling for Adolescents			
Cervical Cancer Screening			
Low Birthweight			
Initiation of Prenatal Care			
Prenatal Care Utilization			
Glycohemoglobin Monitoring			
Ambulatory Follow-Up After Hospitalization for Mental Health Disorders			
Utilization of PCPs, Preventive Services			
Provider Availability (Access)			

[Since many plans do not have access to complete administrative data, they may utilize medical records to supplement their administrative data. A plan's interpretation of the specifications for both the administrative based measures and the measures utilizing medical records can affect the Medicaid HEDIS rates. The State should verify that the measure calculation process used by each plan will meet the HEDIS specifications.]

APPENDIX G
MCO BASELINE ASSESSMENT:
INFORMATION SYSTEM CAPABILITIES

B. Enrollment System

1. Please describe any major changes in the enrollment system(s) which could affect the quality or completeness of the enrollment data.

[Major changes to a plan's enrollment system could involve the conversion of membership data to a new system. When plans convert members, they may change the member's ID number, making it difficult to track the member's enrollment pattern across time. Changes to the enrollment system could also lead to a loss of data for specific patients.]

2. How does your plan uniquely identify members?

[Members should have a single ID number to facilitate tracking their experience. However, some plans change a member's ID number when the member re-enrolls. Experience for members who have switched ID numbers will be more difficult to track. Dependents using a member's ID are also difficult to identify for reporting purposes. For example, children without a unique ID could affect the ability of the plan to report on low birthweight babies, childhood immunizations, and asthma inpatient admissions.]

3. How do you handle member disenrollment and re-enrollment in the same product? Does the member retain the same ID?

[Members should retain the same ID when they re-enroll in the same product to simplify the tracking process. This issue is especially relevant to Medicaid beneficiaries who may have changes in their eligibility status during the course of the year.]

APPENDIX G
MCO BASELINE ASSESSMENT:
INFORMATION SYSTEM CAPABILITIES

C. Ancillary Systems

1. Does your plan incorporate data from vendors to calculate any of the following quality measures? If so, which measures require vendor data?

Measure	Vendor Name
Childhood Immunization Rate(s)	
Well Child Visits	
Initiation of Prenatal Care	
Cervical Cancer Screening	
Low Birthweight	
Prenatal Care in First Trimester	
Substance Abuse Counseling for Adolescents	
Glycohemoglobin Monitoring	
Ambulatory Follow-Up After Hospitalization for Specified Mental health Disorders	
Provider Certification	

[If a plan is using vendor data, the plan should have a formal process in place to validate that data before incorporating it into their information systems. The plans needs to check the vendor data for validity, completeness and timeliness of submission.]

2. Discuss any concerns you may have about the quality or completeness of any vendor data.

[The plan should have staff who are experienced with the vendor's data. Furthermore, most plans will answer this question by saying "we have no concerns." Probe on this issue.]

APPENDIX G
MCO BASELINE ASSESSMENT:
INFORMATION SYSTEM CAPABILITIES

III. COMPENSATION STRUCTURE

The purpose of this section is to evaluate the provider compensation structure, as this may influence the quality and completeness of data. Please identify the percentage of member months in your plan contributed by members whose primary care providers and specialists are compensated through each of the following payment mechanisms.

Payment Mechanism	Provider Type	
	PCP	**Specialist**
1. Salaried		
2. Fee-for-Service - no withhold or bonus		
3. Fee-for-Service with withhold % withhold		
4. Fee-for-service with bonus Bonus range:		
5. Capitated - no withhold or bonus		
6. Capitated with withhold % withhold:		
7. Capitated with bonus Bonus range:		
8. Other:		
TOTAL	**100%**	**100%**

[Timeliness and completeness of provider data submissions often varies by contracting arrangement. Salaried providers work directly for the plan and will submit data on a timely basis if data submission is a parameter in their contract with the plan. Fee-for-service providers have the largest incentive to submit accurate and complete data since their payment depends upon it. Capitated providers will need incentives to submit accurate and complete data. Their compensation should be linked to data submission, which can be done through the use of bonuses and withholds. For example, lag times may differ by compensation arrangement as follows: Capitation/Salaried -no lag, Fee for Service - 60 day lag, Hospital - 45 day lag.]